

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Wicomico</u> <u>16409</u>			Registration Dist. No. <u>333</u>	
Village or City <u>Salisbury</u> (No. <u>N. 1000</u>)			St. <u>9th Dist.</u> Ward <u>8</u>	
2 FULL NAME <u>Elizabeth H. Bell</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>married</u>		
6 DATE OF BIRTH <u>Nov 17th</u> , 18 <u>49</u> (Month) (Day) (Year)				
7 AGE <u>66</u> yrs. <u>5</u> mos. <u>19</u> ds. <u>OR</u> <u>1</u> day. <u>hrs.</u> min. ? If LESS than 1 day, hrs. min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>✓</u>				
9 BIRTHPLACE (State or country) <u>Maryland</u>				
PARENTS	10 NAME OF FATHER <u>William Gundry</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>			
	12 MAIDEN NAME OF MOTHER <u>Jane Summers</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>William S. Bell</u> (Address) <u>7027 Division St. Salisbury Md.</u>				
15 <u>Sept 7th</u> , 191 <u>5</u> <u>M. Turner</u> Filed REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>September 6</u> , 191 <u>5</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>August 17</u> , 191 <u>5</u> , to <u>September 6</u> , 191 <u>5</u> , that I last saw him alive on <u>September 6</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>8-P</u> m.				
The CAUSE OF DEATH* was as follows: <u>Uremic coma due to chronic diffuse nephritis.</u> (Duration) <u>1</u> yrs. <u>1</u> mos. <u>1</u> ds.				
Contributory <u>Dis. colic. vent.</u> Secondary (Duration) <u>19</u> yrs. <u>19</u> mos. <u>19</u> ds.				
(Signed) <u>S. Morris Pichard</u> , M. D. <u>Sept 7</u> , 191 <u>5</u> (Address) <u>Salisbury, Md.</u>				
State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>19</u> yrs. <u>19</u> mos. <u>19</u> ds. In the State <u>19</u> yrs. <u>19</u> mos. <u>19</u> ds. Where was disease contracted, If not at place of death? Former or usual residence.				
19 PLACE OF BURIAL OR REMOVAL <u>Prosser Cem. Salisbury Md.</u> DATE OF BURIAL <u>Sept. 8th</u> <u>4 P.M.</u> , 191 <u>5</u>				
20 UNDERTAKER <u>The Hill & Johnson Co.</u> ADDRESS <u>Salisbury Md.</u>				

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on Statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



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1 PLACE OF DEATH County <u>Wicomico</u> near <u>Sharptown</u>		16010 (5)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Sharptown</u>		No. <u>5</u>		Registration Dist. No. <u>335</u>	
2 FULL NAME		St. <u>Cook</u>		Ward	
[If death occurred in a hospital or institution, give its NAME instead of street and number.]					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Col.</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>Sept. 12, 1915</u> (Month) (Day) (Year)		7 AGE <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. If LESS than 1 day, 0 hrs. OR 0 min.?			
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>—</u> (b) General nature of industry, business, or establishment to which employed (or employer) <u>—</u>					
9 BIRTHPLACE (State or country) <u>Md.</u>					
PARENTS	10 NAME OF FATHER <u>Clarence Cook</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>				
	12 MAIDEN NAME OF MOTHER <u>Virgie Quinton</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (to informant) <u>Clarence Cook</u> (Address) <u>Sharptown Md.</u>					
15 Filed <u>9/12, 1915</u> <u>W. C. Mann</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>9/12/1915</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>1915</u> to <u>1915</u> , that I last saw him alive on <u>1915</u> , and that death occurred on the date stated above, at <u>—</u> m. The CAUSE OF DEATH * was as follows: <u>no doctor in attendance</u> <u>no one in attendance</u> <u>Still-Born</u> (Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds.					
Contributory Secondary (Duration) <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. (Signed) <u>Walter C. Mann</u> Reg. M. D. <u>9/12</u> , 1915 (Address) <u>Sharptown Md.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. In the State, <u>—</u> yrs. <u>—</u> mos. <u>—</u> ds. Where was disease contracted, If not at place of death? Former or usual residence <u>—</u>					
19 PLACE OF BURIAL OR REMOVAL <u>Zion Church</u>				DATE OF BURIAL <u>9/12, 1915</u>	
20 UNDERTAKER <u>W. W. Havenor & Bro. Sharptown</u>				ADDRESS	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia"); *unqualified*, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness" etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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sent out for
signature of Sec. Reg.

RECEIVED
NOV 17 1915
BUREAU, V.S.

RECEIVED
NOV 6 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Wicomico</u>		16011		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Salisbury</u>		(No. <u>P. G. Hospital</u>)		Registration Dist. No. <u>333</u>	
		(No. <u>Camden Dist.</u>)		St. <u>13</u> Ward)	
2 FULL NAME <u>Harry Crockett</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>Not known</u> , 1 (Month) (Day) (Year)					
7 AGE <u>About 28 yrs.</u> OR <u>1 day</u> LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Delaware</u>					
PARENTS	10 NAME OF FATHER <u>Daniel Crockett</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Delaware</u>				
	12 MAIDEN NAME OF MOTHER <u>Not known to me</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Delaware</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Shirley White</u> (Address) <u>Lanrel Del.</u>					
15 Filed <u>Sept. 20, 1915</u> <u>May Turner</u> <u>Salisbury</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Sept. 19</u> , 1915 (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Sept. 18</u> , 1915, to <u>Sept. 19</u> , 1915, that I last saw him alive on <u>Sept. 19</u> , 1915, and that death occurred on the date stated above, at <u>4 P</u> m. The CAUSE OF DEATH* was as follows: <u>Intestinal perforation</u>					
Contributory (Duration) <u>2 yrs.</u> mos. <u>4</u> ds. Secondary <u>Sept. 19, 1915</u> (Address) <u>Salisbury Md</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>2 mos.</u> In the State <u>2 yrs.</u> mos. <u>4</u> ds. Where was disease contracted, <u>Sussex Co. Del.</u> If not at place of death? <u>Sussex Co. Del.</u> Former or usual residence.					
19 PLACE OF BURIAL OR REMOVAL <u>Lanrel Del.</u> DATE OF BURIAL <u>Sept. 21st</u> , 1915.					
20 UNDERTAKER <u>H. O. & E. B. Riggins</u> ADDRESS <u>Lanrel Del.</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

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[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Pebility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Wicomico 16012Village or City Mardela (No. _____)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 330

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Adam Dushie

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Sept 20, 1915
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. 6 ds. If LESS than 1 day _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER Charles C. Dushie

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Adda Weatherly

13 BIRTHPLACE OF MOTHER (State or country) md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles C. Dushie(Address) Mardela

15 Filed _____, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 25, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw h _____ alive on _____, 191____,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:

General Debility

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. L. English Registrar
Sept 25, 1915 (Address) Mardela, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State, _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Col Cemetery Sept 25, 1915

20 UNDERTAKER ADDRESS

Hicks Waller Mardela

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

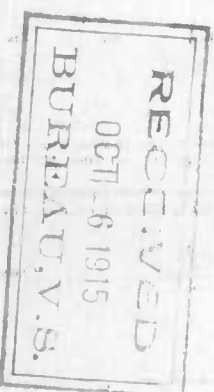
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Cart engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition" "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Roadster wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County McComico 16013

(28)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 330Village or City Hebron (No. _____, _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Anna H. Davis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Dec 28, 1870
(Month) (Day) (Year)

7 AGE 44 yrs. 8 mos. 20 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work House wife
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE
(State or country)Maryland

PARENTS

10 NAME OF FATHER

Lambert Hall11 BIRTHPLACE OF FATHER
(State or country)Maryland

12 MAIDEN NAME OF MOTHER

Onie Danaway13 BIRTHPLACE OF MOTHER
(State or country)Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Whitcomb J. Davis(Address) Hebron No 8

15 Filed Sept 28, 1915 W. S. Phillips
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 18, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from June 2, 1915 to Sept 18, 1915,
that I last saw him alive on 18th, 1915

and that death occurred on the date stated above, at 1 P m.

The CAUSE OF DEATH* was as follows:

Tuberculosis

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. C. Bonawent, M. D.
Sept 18, 1915 (Address) Hebron Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Family burial

DATE OF BURIAL

Sept 20, 1915

20 UNDERTAKER

P. F. Station

ADDRESS

Delbyville

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not faintly employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverter wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
OCT 12 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH
County Wicomico

16014

(79)

Village or City Delmar

(No.)

St.; Ward)

Registration Dist. No. 986

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Sarah Jane Deshields

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDDED, DIVORCED married
(Write the word)

6 DATE OF BIRTH Jan 17, 1885
(Month) (Day) (Year)

7 AGE 28 yrs. 8 mos. 13 ds. OR It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work House keeping
(b) General nature of industry, business, or establishment in which employed (or employer) " "

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER John W. Morris
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Coalman
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Maggie Truitt
(Address) Delmar Dela

15 Filed Sept 2, 1915 W. Y. Lunn
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 1, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1915 to Sept 1, 1915

that I last saw him alive on Sept 31, 1914

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Acetycardia

Recurring attack for 3 yrs. (Duration) yrs. mos. ds.

Contributory None
Secondary

(Duration) yrs. mos. ds.

(Signed) W. Y. Lunn, M. D.
Sept 1, 1915 (Address) Delmar Dela

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL A. B. C. Cem. Vienna Md. DATE OF BURIAL Sept 1, 1915

20 UNDERTAKER M. W. Allen ADDRESS Delmar Dela

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tracmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
OCT - 2 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 16015
 County McMinn
 Village or City Wetumpka (No. 14) St.; Ward
 2 FULL NAME John Desuritch
 Registration Dist. No. 337
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
 4 COLOR OR RACE C
 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single
 6 DATE OF BIRTH no record Sept 7 1915
 (Month) (Day) (Year)
 7 AGE 5 yrs. — mos. — ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work none
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Pa.

PARENTS
 10 NAME OF FATHER Morris Desuritch
 11 BIRTHPLACE OF FATHER (State or country) Philadelphia
 12 MAIDEN NAME OF MOTHER Amelia Desuritch
 13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Amelia Desuritch
 (Address) Wetumpka, Md.

15 Filed Sept. 8, 1915 Lucy D. Wallis
Special REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 7, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That, attended deceased from Aug 28, 1915 to Sept 7, 1915,

that I last saw him alive on Sept 6, 1915

and that death occurred on the date stated above, at 3 A m.

The CAUSE OF DEATH* was as follows:

Coronary
 (Duration) 1 yrs. 2 mos. 2 ds.

Contributory Coronary
 Secondary (Duration) 1 yrs. 2 mos. 2 ds.

(Signed) J. McCombs, M. D.
Sept 7, 1915 (Address) Wetumpka, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 1 yrs. 2 mos. 2 ds. In the State 1 yrs. 2 mos. 2 ds.
 Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Wetumpka, Md. County DATE OF BURIAL Sept 8, 1915

20 UNDERTAKER G. E. McCombs ADDRESS Bivins

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plumber*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
OCT-5 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>McComico</u>		16016		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Netipquin</u> (No. _____)		St.; _____ Ward)		Registration Dist. No. <u>337</u>	
2 FULL NAME <u>Melissia C. Dunn</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)			
6 DATE OF BIRTH <u>May 21, 1863</u> (Month) (Day) (Year)					
7 AGE <u>58</u> yrs. _____ mos. _____ ds. If LESS than 1 day, _____ hrs. OR _____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House-work</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>Richard Carlbourn</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>Dont know</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Dont know</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Ether Dunn</u> (Address) <u>Netipquin Md.</u>					
15 FILED <u>Sept. 2, 1915</u> <u>Lucy J. Galt</u> <u>Local</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Sept 1, 1915</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Aug 31, 1915</u> , to <u>Aug 31, 1915</u> , that I last saw her alive on <u>Aug 31, 1915</u> , and that death occurred on the date stated above, at <u>11 P</u> m.					
The CAUSE OF DEATH* was as follows: <u>Cerebral Hemorrhage</u>					
(Duration) _____ yrs. _____ mos. _____ ds.					
Contributory Secondary (Duration) _____ yrs. _____ mos. _____ ds.					
(Signed) <u>J. R. Warner</u> , M. D. <u>Sept 1, 1915</u> (Address) <u>Nautilus Md</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence.					
19 PLACE OF BURIAL OR REMOVAL <u>Bivalve Md</u> DATE OF BURIAL <u>Sept 2, 1915</u>					
20 UNDERTAKER <u>C. E. Mcnair</u> ADDRESS <u>Bivalve Md</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

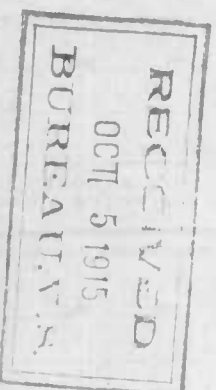
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County WicomicoVillage or City Salisbury (No. Parsons Dist. St. 5 Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Infant of Virgil Elliott

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)6 DATE OF BIRTH Sept - 10, 1915
(Month) (Day) (Year)7 AGE _____ yrs. _____ mos. 1 1/2 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of Industry, business, or establishment in which employed (or employer) _____9 BIRTHPLACE (State or country) Wicomico Co Md.10 NAME OF FATHER Virgil Elliott11 BIRTHPLACE OF FATHER (State or country) Wicomico Co Md.12 MAIDEN NAME OF MOTHER Millie Parsons13 BIRTHPLACE OF MOTHER (State or country) Wicomico Co Md.14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Virgil Elliott(Address) Salisbury Md.15 Filed Sept. 12, 1915 May Turner
Deputy, REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 11, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Sept. 11, 1915, to Sept. 11, 1915.that I last saw him alive on Sept. 11, 1915.and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Convulsions(Duration) _____ yrs. _____ mos. 1 1/2 ds.Contributory
Secondary _____(Signed) D. B. Potter, M. D.Sept. 12, 1915 (Address) Salisbury Md.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Parsons Cemetery DATE OF BURIAL Sept. 12, 191520 UNDERTAKER The Hill & Johnson Co ADDRESS Salisbury Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Typhemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Wiconisco

16018

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 330Village or City Hebron

(No. _____)

St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

William H. Cronis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

Black

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Aug 5, 1910
(Month) (Day) (Year)

7 AGE

5 yrs. 1 mos. 13 ds. OR LESS than 1 day, _____ hrs. _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work _____

(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE

(State or country) Wiconisco

PARENTS

10 NAME OF FATHER

Charley Cronis

11 BIRTHPLACE OF FATHER

(State or country) Wiconisco

12 MAIDEN NAME OF MOTHER

Mary Moore

13 BIRTHPLACE OF MOTHER

(State or country) Wiconisco

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Charley Cronis

(Address)

Hebron

15

Filed _____

, 1911

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 21, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Sept 15, 1915, to Sept 21, 1915.that I last saw him alive on Sept 21, 1915.and that death occurred on the date stated above, at 4 P m.

The CAUSE OF DEATH* was as follows:

Typhoid Fever

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary _____

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

H. B. Comanzo

M. D.

Sept 21, 1915(Address) Hebron Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Maidell Springs Sept 23, 1915

20 UNDERTAKER

ADDRESS

A. L. Siabre Maidell Springs

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Prosy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as *fracture of skull*, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
OCT. 6 1915
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Wilconico 16019STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 333Village or City Salisbury (No. Salisbury Dist St. 9 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Laurie Evans

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE a. a. 5 SINGLE, - Single
MARRIED, WIDDED, OR DIVORCED (Write the word)

6 DATE OF BIRTH February 12, 1915
(Month) (Day) (Year)7 AGE 7 yrs. 18 mos. 18 ds. If LESS than 1 day, hrs. OR, min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Wilconico Co. Md

10 NAME OF FATHER James Evans
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Laurie James
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Laurie Evans(Address) Present Salisbury md15 Filed Sept 30, 1915 R. P. Turner

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 30, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Only reviewed to name 9-30, 1915
that I last saw h alive on, 1915and that death occurred on the date stated above, at 3:30 P. m.

The CAUSE OF DEATH* was as follows:

Chronic bronchitis(Duration) yrs. 7 mos. 18 ds.Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) J. W. Roberts, M. D.
Sept 30, 1915 (Address) Salisbury, Md

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Co DATE OF BURIAL Sept 2, 191520 UNDERTAKER Rachellek Sonnet ADDRESS Salisbury, MdE. Stewart

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such. If impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Wicomico

16020

164

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 337Village or City Wetipquin Rd No. _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME George Edison Furber

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH June 26, 1915
(Month) (Day) (Year)7 AGE _____ yrs. 2 mos. 28 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER George M. Furber11 BIRTHPLACE OF FATHER (State or country) Maryland12 MAIDEN NAME OF MOTHER Mary Anna Hurley13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Geo M. Furber(Address) Wetipquin Rd.15 Filed Sept 27, 1915 Lucy J. Walter

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 19, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1915, to Sept 19, 1915that I last saw him alive on Sept 19, 1915and that death occurred on the date stated above, at 1 P. m.

The CAUSE OF DEATH* was as follows:

malnutrition
Acute intestinal indigestion(Duration) _____ yrs. _____ mos. 21 ds.Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. R. Warner, M. D.
Sept 19, 1915 (Address) Baltimore

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Wetipquin Rd. DATE OF BURIAL Sept 20, 1915
Family burying ground20 UNDERTAKER C. E. Messick ADDRESS Baltimore

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hemiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septiciæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
OCT. 5 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Wicomico

16021

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 333Village or City Salisbury (No. Carroll Dist. St.; 13 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant - Godwin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED OR DIVORCED single
(Write the word)

6 DATE OF BIRTH Aug 16, 1913
(Month) (Day) (Year)

7 AGE 1 yrs. 7 mos. 7 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Md

PARENTS
10 NAME OF FATHER Leroy Godwin
11 BIRTHPLACE OF FATHER (State or country) Md
12 MAIDEN NAME OF MOTHER Eddie P Jenkins
13 BIRTHPLACE OF MOTHER (State or country) Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Leroy Godwin(Address) Salisbury Md

15 Filed Sept 24, 1913 by May Turner
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 24, 1913
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw h_____ alive on _____, 191____,

and that death occurred on the date stated above, at 3 P. m.

The CAUSE OF DEATH * was as follows:

Had no doctor until from birth and died with convulsions

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. E. Smith M. D.
Sept 24, 1913 (Address) Salisbury Md

* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State, _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Batters field DATE OF BURIAL Sept 24, 1913

20 UNDERTAKER Halloway & Co ADDRESS Salisbury Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Trocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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¹ PLACE OF DEATH
County Montgomery

16022



STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 331

Village or City Seatons (No. _____)

St. _____ Ward _____

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME Encenia Goble

PERSONAL AND STATISTICAL PARTICULARS

³ SEX Female ⁴ COLOR OR RACE Negro ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED Widow
(Write the word)

⁶ DATE OF BIRTH No record, 1834
(Month) (Day) (Year)

⁷ AGE About 81 years If LESS than 1 day.....hrs. OR.....min. ?
yrs. mos. ds.

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work Retired
(b) General nature of industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE (State or country) Maryland

¹⁰ NAME OF FATHER Joshua Porter

¹¹ BIRTHPLACE OF FATHER (State or country) Maryland

¹² MAIDEN NAME OF MOTHER Kennetta Horsey

¹³ BIRTHPLACE OF MOTHER (State or country) Maryland

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Columbus Horsey

(Address) Seatons, Md.

¹⁵ Filed _____, 191_____ REGISTRAR

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH Sept 8, 1915
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from Sept 1st, 1915, to Sept 8, 1915.

that I last saw him alive on Sept 8, 1915.

and that death occurred on the date stated above, at 24 m.

The CAUSE OF DEATH* was as follows:

Symptoms

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory (Secondary)

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. D. Carpenter, M. D.
Sept 9, 1915 (Address) Seatons, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR REGENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

¹⁹ PLACE OF BURIAL OR REMOVAL Seatons Md DATE OF BURIAL Sept 9, 1915

²⁰ UNDERTAKER Jon Jones ADDRESS Seatons, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

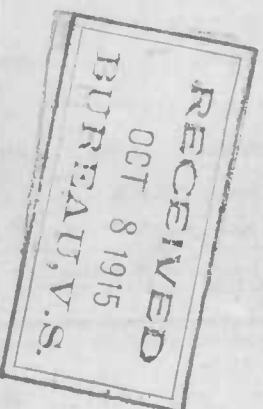
Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of _____ (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 *ds.*; *Bronchopneumonia* (secondary), 10 *ds.* Never report more symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage, as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Missouri</u>			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>Salisbury</u>			Registration Dist. No. <u>833</u>		
2 FULL NAME <u>Ltly M Holloway</u>			[If death occurred in a hospital or institution, give its NAME instead of street and number.]		
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDDED, OR DIVORCED <u>Widow</u> (Write the word)			
6 DATE OF BIRTH <u>Dec 28, 1847</u> (Month) (Day) (Year)					
7 AGE <u>67</u> yrs. <u>8</u> mos. <u>9</u> ds. If LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>House work</u> (b) General nature of industry business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Md</u>					
PARENTS	10 NAME OF FATHER <u>Elisha Holloway</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>				
	12 MAIDEN NAME OF MOTHER <u>Sally McLee</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>S. J. Holloway</u> (Address) <u>P.O. Box 202 Salisbury Md</u>					
15 <u>Sept 7</u> , 1915 <u>M. Turner</u> Filed REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Sept 7</u> , 1915 (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Aug 20</u> , 1915, to <u>Sept 7</u> , 1915, that I last saw her alive on <u>Sept 7</u> , 1915, and that death occurred on the date stated above, at <u>4</u> p. m. The CAUSE OF DEATH * was as follows: <u>Exhaustion & repair</u>					
Contributory <u>Carcinoma of liver</u> Secondary (Duration) yrs. mos. ds. <u>2</u>					
(Signed) <u>Sept 7, 1915</u> (Address) <u>Salisbury Md</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. <u>14</u> ds. In the State, yrs. mos. ds. <u>Sept 7</u> Where was disease contracted, If not at place of death? <u>Missouri, Md</u> Former or usual residence <u>Missouri Cr. Md</u>					
19 PLACE OF BURIAL OR REMOVAL <u>Parson's</u> DATE OF BURIAL <u>Sept 9, 1915</u>					
20 UNDERTAKER <u>Holloway & Co</u> ADDRESS <u>Salisbury Md</u>					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Caretaker," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite, avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds*; *Bronchopneumonia* (secondary), *10 ds*. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means or injury and qualify as *ACCIDENTAL*, *suicidal*, or *homicidal*, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbohc acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Wilcomico

16024

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 333Village or City Near Salisbury (No. Parsons Ist St.; 5 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

At anyJohnson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

male

4 COLOR OR RACE

a. a.5 SINGLE, single
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

Sept 23, 1915
(Month) (Day) (Year)

7 AGE

— yrs. — mos. — ds. OR — min. ?
If LESS than 1 day, 3 hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work

rat any

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)Maryland

PARENTS

10 NAME OF FATHER

Philip Johnson11 BIRTHPLACE OF FATHER
(State or country)Maryland

12 MAIDEN NAME OF MOTHER

Annie Hudson13 BIRTHPLACE OF MOTHER
(State or country)Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Philip Johnson

(Address)

Salisbury Md

15

Filed

Sept 23, 1915 V. S. No. 1

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 23, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

_____, 191____, to _____, 191____.

that I last saw h_____ alive on _____, 191____.

and that death occurred on the date stated above, at 2 P m.

The CAUSE OF DEATH* was as follows:

Had no doctor
premature birth of
7 months

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed)

C. R. Smith, M. D.Sept 23, 1915 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salisbury Cemetery Sept 24, 1915

20 UNDERTAKER

ADDRESS

G. E. Stewart Salisbury Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Crup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septichæ-mia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Wisconsin

16025

104

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

333

Village or City

Near Fruitland, Trappe Dist.

St.; 7 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Infant of Thomas L Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Girl

4 COLOR OR RACE

Anglo-Saxon

5 SINGLE,
MARRIED,
WIDOWED
OR DIVORCED

Write the word Single

6 DATE OF BIRTH

Dec 2, 1914
(Month) (Day) (Year)

7 AGE

9 yrs. 9 mos. 9 ds.

If LESS than
1 day, hrs.
OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

none

(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Md.

PARENTS

10 NAME OF FATHER

Thomas Jones

11 BIRTHPLACE OF FATHER

(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Blanche Causey

13 BIRTHPLACE OF MOTHER

(State or country)

Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Thomas L. Jones

(Address)

Fruitland Md.

15

Filed

Sept 12, 1915. May Turner

Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 11, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from
Sept 5, 1915, to Sept 11, 1915,

that I last saw her alive on Sept 11, 1915,

and that death occurred on the date stated above, at 1:30 p.m.

The CAUSE OF DEATH * was as follows:

acute Dysentery

(Duration) yrs. mos. 17 ds.

Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed)

Jos. L. McLaughlin

M. O.

Sept 11, 1915 (Address) Fruitland Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death yrs. mos. ds.

In the

State, yrs. mos. ds.

Where was disease contracted,

if not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Fruitland

Sept 12th 8 p.m. 1915

20 UNDERTAKER

ADDRESS

The Hill & Johnson Co. Salisbury

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Form laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asthenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Atrrophy," "Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reckless wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telæmia*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Wicomico 18026STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 337Village or City Nanticoke (No. _____ St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Amie B Long

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE C 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) _____

6 DATE OF BIRTH July 24, 1915
(Month) (Day) (Year)

7 AGE _____ yrs. 2 mos. 6 ds. It LESS than 1 day. _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER Proctor Long
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Giorgianna Wallace
13 BIRTHPLACE OF MOTHER (State or country) Kud

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Proctor Long(Address) Nanticoke

15 Filed Sept 30, 1915 Lucy J. Waller
LOCAL REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 30, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.

that I last saw him _____ alive on _____, 191____.

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

No Physician in attendance
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary _____

(Signed) Lucy J. Waller Local Registrar
Sept 30, 1915 (Address) Nanticoke, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Nanticoke M E Cemetery DATE OF BURIAL Sept 30, 1915

20 UNDERTAKER Local ADDRESS Maryland

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plantor*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile" etc.), "Dropsy," "Exhaustion," "Genital," "Heart failure," "Hæmorrhage," "Infantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
OCT. 5 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Wicomico 16027
Village or City Tyaskin (No. 76) St.; Ward)
2 FULL NAME Etta M. Messick
Registration Dist. No. 337
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Nov 7th, 1879
(Month) (Day) (Year)

7 AGE 35 yrs. 10 mos. 20 ds. OR 1 day hrs. min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION
☒ (a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER Alexandra P. Messick
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Mary A. Anderson
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
(Informant) Mrs R. Messick
(Address) Tyaskin Md

15 Filed Sep 27, 1915 Lucy J. Batten
Local REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 26, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Aug 10, 1915, to Sept 26, 1915;
that I last saw her alive on Sept 25, 1915

and that death occurred on the date stated above, at 4:30 A m.

The CAUSE OF DEATH* was as follows:

Pellagra
(Duration) 4 yrs. 0 mos. 0 ds.

Contributory
Secondary

(Duration) 0 yrs. 0 mos. 0 ds.
(Signed) J. Wanner, M. D.
Sept 26, 1915 (Address) Hartwick, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 0 yrs. 0 mos. 0 ds. In the State 0 yrs. 0 mos. 0 ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Tyaskin Md. Cemetery DATE OF BURIAL Sept 28, 1915

20 UNDERTAKER E. G. Messick ADDRESS Bivalve Rd

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septichæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT 5 1915

MINNAPAT, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County

Wicomico

16026

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

337

Village or City

Pawtucket

(No.)

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Messick

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH

Sept 21, 1915
(Month) (Day) (Year)

7 AGE

..... yrs. mos. ds. OR LESS than 1 day, 2 hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Maryland

PARENTS

10 NAME OF FATHER

Phillips Frank Messick

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Pearl H. Messick

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

J. M. Warner M. D.

(Address)

Pawtucket

15

Filed

Sept 21, 1915 Lucy L. Vatter

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 21, 1915
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Sept 21, 1915, to Sept 21, 1915

that I last saw him/her alive on

Sept 21, 1915

and that death occurred on the date stated above, at 10 A m.

The CAUSE OF DEATH* was as follows:

Premature Labor

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

J. M. Warner M. D.

Sept 21, 1915 (Address) Pawtucket

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pawtucket Cemetery

Sept 21, 1915

20 UNDERTAKER

ADDRESS

C. E. Messick

Burial

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

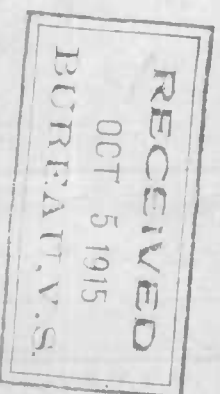
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County

Wicomico

16029

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

323

Village or City

Salisbury

(No.

Camden Dist. St. 13th

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Maudie M. Miller

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Oct.

29th

1894

(Month)

(Day)

(Year)

7 AGE

30

yrs.

10

mos.

21

ds.

11 LESS than 1 day, hrs.

OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Accomac Co. Va.

PARENTS

10 NAME OF FATHER

William Kellam

11 BIRTHPLACE OF FATHER (State or country)

Virginia

12 MAIDEN NAME OF MOTHER

Lottie B. Blandick

13 BIRTHPLACE OF MOTHER (State or country)

Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

W. J. Miller

(Address)

2200 P.O. Accomac Co. Va.

15

Filed

Sept. 20, 1915

S. Gray Turner, Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept. 20, 1915

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

Sept. 20, 1915, to Sept. 20, 1915

that I last saw him alive on Sept. 20, 1915

and that death occurred on the date stated above, at 4:50 p.m.

The CAUSE OF DEATH* was as follows:

Choking from food vomited

Contributory
Secondary

(Duration) Immediate yrs. mos. ds.

(Duration) yrs. mos. ds.

(Signed)

M. D.

Sept. 20, 1915 (Address) Salisbury Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

2200 P.O. Accomac Co. Va. Sept. 21st, 1915

20 UNDERTAKER

ADDRESS

The Hall & Johnson Co. Salisbury Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scullie," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Winnic</u>		16030		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Salisbury</u>		(No. <u>Examination Dist</u>)		Registration Dist. No. <u>333</u>	
2 FULL NAME <u>Eva Moore</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>single</u> (Write the word)			
6 DATE OF BIRTH <u>10 second of month</u> (Month) (Day) (Year) <u>1903</u>		17 I HEREBY CERTIFY, that I attended deceased from <u>Aug 25</u> , 191 <u>5</u> , to <u>Sept 3</u> , 191 <u>5</u> , that I last saw her alive on <u>Sept 3</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>4</u> a.m.			
7 AGE <u>12</u> yrs. <u>4</u> mos. <u>—</u> ds.		It LESS than 1 day, <u>—</u> hrs. OR <u>—</u> min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>School girl</u> (b) General nature of industry business, or establishment in which employed (or employer)		16 DATE OF DEATH <u>Sept 3</u> , 191 <u>5</u> (Month) (Day) (Year)			
9 BIRTHPLACE (State or country) <u>Md</u>		The CAUSE OF DEATH was as follows: <u>General Pink eye</u>			
10 NAME OF FATHER <u>Noah Moore</u>		Contributory <u>Gangrene appendicitis</u> Secondary <u>Embolism</u>			
11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>		(Duration) yrs. mos. ds.			
12 MAIDEN NAME OF MOTHER <u>Annie Waters</u>		(Duration) yrs. mos. ds.			
13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>		(Signed) <u>M. D.</u> <u>Sept 3, 1915</u> (Address) <u>Salisbury Md</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>E. G. Massick</u> (Address) <u>Birdsall Md</u>		*State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.			
15 Filed <u>Sept 3</u> , 191 <u>5</u> <u>E. G. Massick</u> REGISTRAR		18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted if not at place of death? <u>in community, Md</u> Former or usual residence <u>in community, Md</u>			
		19 PLACE OF BURIAL OR REMOVAL <u>W. L. Moore Md</u>		DATE OF BURIAL <u>Sept 4</u> , 191 <u>5</u>	
		20 UNDERTAKER <u>Halloway & Co</u>		ADDRESS <u>Salisbury</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the DISEASE CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Muscles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthma," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County

Anne Arundel

16931

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

333-

Village or City

Near Sharptown

(No.)

St.

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Herbert R. Nichols

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

6 DATE OF BIRTH

Oct 19, 1912
(Month) (Day) (Year)

7 AGE

2 yrs. 11 mos. ds. OR 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

West Va.

PARENTS

10 NAME OF FATHER

Herbert Nichols

11 BIRTHPLACE OF FATHER
(State or country)

West Va.

12 MAIDEN NAME OF MOTHER

Maggie E. Morgan

13 BIRTHPLACE OF MOTHER
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Herbert Nichols

(Address)

Riverton, Md.

15

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 19, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Sept 13, 1915, to Sept 19, 1915.

that I last saw him alive on Sept 19, 1915.

and that death occurred on the date stated above, at 11 2 m.

The CAUSE OF DEATH* was as follows:

Infantile Paralysis
(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

C. E. James, M. D.

Sept 20, 1915 (Address) Sharptown, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Riverton

Sept 20, 1915

20 UNDERTAKER

ADDRESS

W. H. Travers, W. B. Sharptown, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

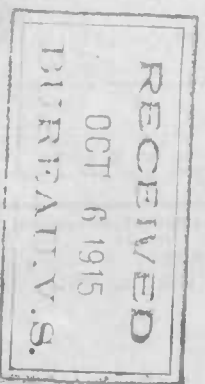
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Fraema," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Wimico

16032

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 336Village or City near Delmar Del. (No.)

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Mr. Emma

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH 9 8, 1915
(Month) (Day) (Year)

7 AGE Dead Born it LESS than 1 day, hrs. yrs. mos. ds. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer) None

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER William J. Nichols

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Sallie L. Hitchens

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) William J. Nichols(Address) Delmar Del.

15 Filed Sept 9, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 9 8, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from 191... to 191...

that I last saw h..... alive on 191...

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

Still Born

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) James Bryshaw, M. D.
2-4, 1915 (Address) Delmar Del.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Nichols Cemetery DATE OF BURIAL Sept 4, 1915

20 UNDERTAKER Mrs. S. Marvel Delmar Del. ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
OCT 2 1915
BUREAU, U. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Hicomico Co</u> 16033		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>R.D. Salisbury Md</u>		Registration Dist. No. <u>3321</u>	
2 FULL NAME <u>James M. Ralph</u>		St.; Ward	
[If death occurred in a hospital or institution, give its NAME instead of street and number.]			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>Widower</u> (Write the word)	
6 DATE OF BIRTH <u>no record exact year, 1843</u> (Month) (Day) (Year)			
7 AGE <u>72</u> yrs. - mos. - ds.		If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry business, or establishment in which employed (or employer) <u>Farming</u>			
9 BIRTHPLACE (State or country) <u>USA</u>			
PARENTS	10 NAME OF FATHER <u>Dont Know</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Dont Know</u>		
	12 MAIDEN NAME OF MOTHER <u>Dont Know</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Dont Know</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Sarah Jefferson</u> (Address) <u>R.D. 2 Salisbury Md</u>			
15 Filed <u>9</u> , 191 <u>5</u> <u>H. J. Truitt</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Sept 6</u> , 191 <u>5</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>July 12</u> , 191 <u>5</u> , to <u>Sept 5</u> , 191 <u>5</u> , that I last saw him alive on <u>Sept 5</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>md</u> . The CAUSE OF DEATH was as follows: <u>Initial Dysentery</u>			
Contributory Secondary <u>Bilious Dysentery</u> (Duration) <u>2</u> yrs. mos. ds.			
(Signed) <u>R. J. Truitt</u> , M. O. <u>Sept 5</u> , 191 <u>5</u> . (Address) <u>Salisbury Md</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>md</u> yrs. mos. ds. In the State, <u>md</u> yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL <u>Ralph Hill</u>		DATE OF BURIAL <u>September 7, 1915</u>	
20 UNDERTAKER <u>J. Rathell Harlow</u>		ADDRESS <u>Wallards md</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

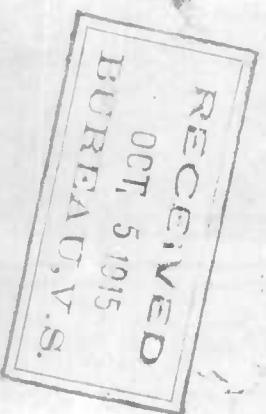
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, menin-

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*, *Chronic valvular heart disease*, *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths, state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 16034 P. G. Hospital STATE OF MARYLAND
 County Frederick CERTIFICATE OF DEATH
 Registration Dist. No. 333
 Village or City Salisbury (No. 9 St. 13 Ward)
 2 FULL NAME Mr. James Pritchard [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
 (Write the word)

6 DATE OF BIRTH Sept. 25, 1915
 (Month) (Day) (Year)

7 AGE 6 mos. abortion If LESS than 1 day, hrs. yrs. mos. ds. OR min. ?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Frederick Co., Md.

PARENTS

10 NAME OF FATHER James Pritchard

11 BIRTHPLACE OF FATHER (State or country) Frederick Co., Md.

12 MAIDEN NAME OF MOTHER Bessie Brittingham

13 BIRTHPLACE OF MOTHER (State or country) Frederick Co., Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) James Pritchard
 (Address) Salisbury, Md.

15 Filed Sept 25, 1915 J. N. P. Thomas REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept. 25, 1915
 (Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from Sept. 25, 1915, to Sept. 25, 1915,
 that I last saw him alive on Sept. 25, 1915,
 and that death occurred on the date stated above, at an unknown date m.
 The CAUSE OF DEATH* was as follows:
Unknown

(Duration) yrs. mos. ds.

Contributory Secondary Unknown
 (Duration) yrs. mos. ds.

(Signed) James Pritchard, M. D.
Sept. 25, 1915 (Address) Salisbury, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)
 At place of death yrs. mos. ds. In the State yrs. mos. ds.
3 yrs. 3 mos. 3 ds. State Lifetime

Where was disease contracted, if not at place of death? four weeks co md

Former or usual residence four weeks co md

19 PLACE OF BURIAL OR REMOVAL P. G. Hospital DATE OF BURIAL Sept 25, 1915

20 UNDERTAKER Superintendent ADDRESS Mrs. Brown Salisbury Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Ivanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Wicomico</u>		16035 (79)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>near Salisbury</u> (No. <u>R D #4</u>)		St. <u>8</u> Ward <u>8</u>		Registration Dist. No. <u>333</u>	
2 FULL NAME <u>John Ruark</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED. (Write the word) <u>Widowed</u>			
6 DATE OF BIRTH <u>Oct 23</u> , 18 <u>33</u> (Month) (Day) (Year)					
7 AGE <u>81</u> yrs. <u>10</u> mos. <u>26</u> ds. If LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Md</u>					
PARENTS					
10 NAME OF FATHER <u>John Ruark</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>					
12 MAIDEN NAME OF MOTHER <u>Lillie Richardson</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Lee Ruark</u> (Address) <u>Salisbury Md R D #4</u>					
15 Filed <u>Sept 20</u> , 191 <u>5</u> <u>May Turner</u> Deputy REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Sept 19</u> , 191 <u>5</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>July 1st</u> , 191 <u>5</u> , to <u>July 4th</u> , 191 <u>5</u> , that I last saw him alive on <u>July 4th</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>5:30 a.m.</u>					
The CAUSE OF DEATH* was as follows: <u>only saw him hrs. prior to and</u> <u>detected history since above date</u> <u>known</u> <u>Informant of Age</u> (Duration) yrs. mos. ds. <u>don't know</u> <u>Contributory</u> <u>Heart (Valvular Disease)</u> (Duration) yrs. mos. ds. <u>don't know</u> (Signed) <u>Em. H. Todd</u> M. D. <u>Sept 19th</u> , 191 <u>5</u> (Address) <u>Salisbury Md</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2), whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>8-District</u> DATE OF BURIAL <u>Sept 20</u> , 191 <u>5</u> <u>Ernest Byker</u>					
20 UNDERTAKER <u>Halloway & Co</u> ADDRESS <u>Salisbury Md</u>					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association]

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Statement of Cause of Death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

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1 PLACE OF DEATH

County

16036

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

Village or City

(No.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

6 DATE OF BIRTH

7 AGE

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER (State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER (State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

Filed

191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

17

I HEREBY CERTIFY, That I attended deceased from

that I last saw h. alive on

and that death occurred on the date stated above, at

The CAUSE OF DEATH* was as follows:

Contributory
Secondary

(Signed)

9-16

1915 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

20 UNDERTAKER

ADDRESS

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Furn laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Wicomico

16037

104

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 338Village or City Hebron (No. _____)Hebron Dist St.: 15 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Paul Taylor

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH April 30th, 1915
(Month) (Day) (Year)

7 AGE 4 yrs. 20 mos. 20 ds. OR 1 day, _____ hrs. _____ min. ?
If LESS than

8 OCCUPATION
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Hebron Md.

PARENTS
10 NAME OF FATHER Winfield S. Taylor
11 BIRTHPLACE OF FATHER (State or country) Somerset Co. Md.
12 MAIDEN NAME OF MOTHER Sarah E. Cansey
13 BIRTHPLACE OF MOTHER (State or country) Wicomico Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Winfield S. Taylor(Address) Hebron Md.

15 Filed Sept 21, 1915 H. S. Phillips
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 20, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1915, to Sept 20, 1915, that I last saw him alive on Sept 6, 1915

and that death occurred on the date stated above, at 1:30 P.m.

The CAUSE OF DEATH* was as follows:

Sho. colic(Duration) _____ yrs. _____ mos. 1 ds.Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. Morris Pilehouse, M. D.
Sept 20, 1915 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,
If not at place of death?

Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL Mt. Vernon Cemetery, Salisbury Md. DATE OF BURIAL Sept 21st, 1915

20 UNDERTAKER The Hill & Johnson Co. ADDRESS Salisbury Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Scalle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
OCT 2 1915
BUREAU, U. S.

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1 PLACE OF DEATH

County Wicomico

16038

104

Village or City Hebron (No.)STATE OF MARYLAND.
CERTIFICATE OF DEATHRegistration Dist. No. 338St. 15th Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Pauline Taylor

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
6 DATE OF BIRTH <u>April 30th</u> , 1915 (Month) (Day) (Year)		
7 AGE <u>4</u> yrs. <u>21</u> mos. <u>21</u> ds. OR <u>1</u> day, <u>1</u> hrs. <u>1</u> min. ? If LESS than 1 day, hrs. min. ?		

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

None9 BIRTHPLACE
(State or country)Hebron Md

PARENTS

10 NAME OF FATHER

Winfield S. Taylor11 BIRTHPLACE OF FATHER
(State or country)Maryland

12 MAIDEN NAME OF MOTHER

Sarah E. Causey13 BIRTHPLACE OF MOTHER
(State or country)Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Winfield S. Taylor

(Address)

Hebron Md

15

Filed

Sept 22, 1915

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 21, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Sept 6, 1915, to Sept 21, 1915.that I last saw him alive on Sept 6, 1915.and that death occurred on the date stated above, at 4:30 P m.

The CAUSE OF DEATH* was as follows:

Dis Colic(Duration) yrs. mos. 1 ds.Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Samuel Phillips, M. D.Sept 21, 1915 (Address) Salisbury, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Hebron Md.Sept. 22nd, 1915.

20 UNDERTAKER

ADDRESS

The Hill & Johnson Co. SalisburyMd.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

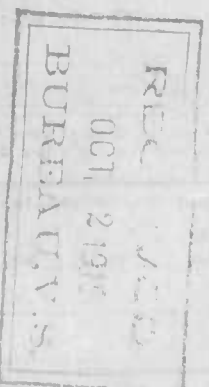
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia; Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc., Carcinoma, Sarcoma, etc., of.....* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc.* The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trachma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide.* The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Wicomico</u>		16039 <u>64</u>		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Salisbury</u> (No. <u>Salisbury Dist.</u> St. <u>9</u> Ward)		Registration Dist. No. <u>993</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Crest A. Goadwine</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDDED, OR DIVORCED (Write the word) <u>married</u>			
6 DATE OF BIRTH <u>Oct. 14</u> , 18 <u>60</u> (Month) (Day) (Year)					
7 AGE <u>54</u> yrs. <u>10</u> mos. <u>29</u> ds. <u>OR</u> 1 day.....hrs. <u>OR</u>min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Clk of Circuit Court</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Salisbury, Md</u>					
PARENTS	10 NAME OF FATHER <u>Stephen P. Goadwine</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>Mary Ann Quirk</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. Crest A. Goadwine</u> (Address) <u>Salisbury, Md</u>					
15 Filed <u>Sept. 13</u> , 191 <u>5</u> ; <u>May Turner</u> Deputy REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Sept 13</u> , 191 <u>5</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Sept 13</u> , 191 <u>5</u> , to <u>Sept 13</u> , 191 <u>5</u> , that I last saw him alive on <u>Sept 13</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>9.30 a.m.</u> , The CAUSE OF DEATH* was as follows: <u>Cerebral Apoplexy</u> <u>Three minutes</u> (Duration) yrs. mos. ds.					
Contributory Secondary (Duration) yrs. mos. ds. Signed <u>Harry G. Guel</u> , M. D. <u>Sept 13</u> , 191 <u>5</u> (Address) <u>Salisbury</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death..... yrs. mos. ds. In the State..... yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence.....					
19 PLACE OF BURIAL OR REMOVAL <u>Parsons Cemetery, Salisbury</u>				DATE OF BURIAL <u>9/15/15</u> , 191 <u>5</u>	
20 UNDERTAKER <u>The Hill & Johnson Co. Salisbury, Md</u>				ADDRESS	

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1 PLACE OF DEATH County <u>Thiomas</u>		16040		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Hebron</u> (No.)		(40)		Registration Dist. No. <u>338</u>	
2 FULL NAME <u>David L. Trader</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>May 5, 1842</u> (Month) (Day) (Year)		16 DATE OF DEATH <u>Sept 25, 1915</u> (Month) (Day) (Year)			
7 AGE <u>73</u> yrs. <u>4</u> mos. <u>20</u> ds. OR LESS than 1 day, ... hrs. ? OR ... min. ?		17 I HEREBY CERTIFY, That I attended deceased from <u>May 1, 1915</u> to <u>Sept 25, 1915</u> , that I last saw him alive on <u>Sept 20, 1915</u> , and that death occurred on the date stated above, at <u>2 P. m.</u> , The CAUSE OF DEATH* was as follows: <u>Cancer of Stomach & nephritis</u>			
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Labour</u> (b) General nature of industry, business, or establishment in which employed (or employer)		(Duration) ... yrs. ... mos. ... ds.			
9 BIRTHPLACE (State or country) <u>Maryland</u>		Contributory Secondary (Duration) ... yrs. ... mos. ... ds.			
PARENTS	10 NAME OF FATHER <u>Samuel Trader</u>	(Signed) <u>H. C. Bonmarway</u> , M. D. <u>Sept 25, 1915</u> (Address) <u>Hebron md</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>	*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
	12 MAIDEN NAME OF MOTHER <u>Maria Townsend</u>	18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ... yrs. ... mos. ... ds. In the State ... yrs. ... mos. ... ds. Where was disease contracted, If not at place of death? Former or usual residence			
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>	19 PLACE OF BURIAL OR REMOVAL <u>Hebron Cemetery</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. L. Bailey</u> (Address) <u>Hebron</u>		20 UNDERTAKER <u>The Hill & Johnson Co</u>		DATE OF BURIAL <u>9/27/15</u> , 191	
15 Filed <u>Sept 25, 1915</u> <u>H. S. Phillips</u> REGISTRAR		ADDRESS <u>Salisbury, Md.</u>			

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

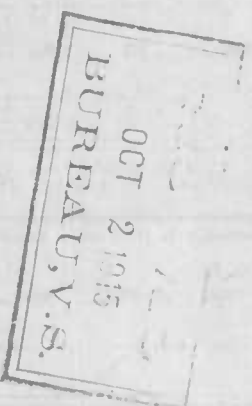
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

County Wicomico 16041Village or City Willards (No. 104) St.; WardSTATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 332

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Elvly E. Smith

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDDED OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH April 22, 1913
(Month) (Day) (Year)

7 AGE 0 yrs. 4 mos. 18 ds. If LESS than 1 day, hrs. OR min.?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Georgel Smith

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Effie Dickerson

13 BIRTHPLACE OF MOTHER (State or country) Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) General Smith

(Address) Willards Md.

15 Filed 9, 1913 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 9, 1913
(Month) (Day) (Year)

17 HEREBY CERTIFY, That I attended deceased from ap 22, 1913, to Sept. 9, 1913.

that I last saw her alive on Sept 5, 1913.

and that death occurred on the date stated above, at 7 A m.

The CAUSE OF DEATH was as follows:

Gastroenteritis
(Duration) yrs. 1 mos. ds.

Contributory Maternal Birth
Secondary

(Signed) C. A. Holman, M. D.
Sept 10, 1913 (Address) Whaleymills Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL New Hope DATE OF BURIAL Sept 10, 1913

20 UNDERTAKER G. Rathiff Harlow ADDRESS Willards

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

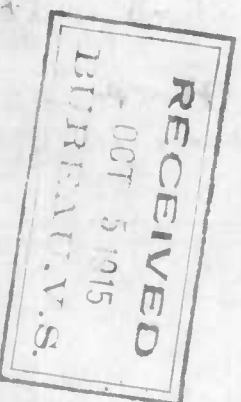
[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Trocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Cool mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County Hagerman 16042Village or City Tyaskin (No. 104)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 337

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Charlotte M. Haining

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE C 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) WIDOWED

6 DATE OF BIRTH May 23, 1914
(Month) (Day) (Year)

7 AGE 1 yrs 3 mos 23 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER John R. Haining

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Evelene Jones

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jos. R. Haining

(Address) Tyaskin Md

15 Filed Sept. 14, 1915 Lacey J. Hatter REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 13, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 12th, 1915, to Sept 12th 1915, that I last saw him alive on Sept 12th, 1915

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:
Diphtheria, Enteritis

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.
(Signed) R. E. Caldwell, M. D.
Sept 17, 1915 (Address) Buwalde Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Tyaskin Md. Cemetery Sept 14, 1915
UNDERTAKER C. G. Merich ADDRESS Buwalde Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-fusional," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
OCT. 5 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
 County Wicomico 16043 168
 Village or City Salisbury P. G. Hospital (No. Camden Dist. St.; 13th Ward)
2 FULL NAME George W. Ward
 Registration Dist. No. 333
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male
4 COLOR OR RACE White
5 SINGLE, MARRIED, WIDDED, OR DIVORCED Married
 (Write the word)
6 DATE OF BIRTH May 2, 1854
 (Month) (Day) (Year)
7 AGE 61 yrs. 4 mos. 14 ds. If LESS than 1 day,....hrs. OR....min.?

8 OCCUPATION
 (a) Trade, profession, or particular kind of work Farmer
 (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Virginia

PARENTS
10 NAME OF FATHER Charles Ward
11 BIRTHPLACE OF FATHER (State or country) Virginia
12 MAIDEN NAME OF MOTHER Not known
13 BIRTHPLACE OF MOTHER (State or country) Not known

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W. E. Tull
 (Address) Stockton, Md.

15 Filed Sept 16, 1915 3: May Turner
 Deputy, REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 16, 1915
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 10, 1915, to Sept 16, 1915,
 that I last saw him alive on Sept 16, 1915.

and that death occurred on the date stated above, at 8:30 A. m.

The CAUSE OF DEATH* was as follows:

General pneumonia

(Duration) yrs. mos. 21 ds.

Contributory Gangrene of foot
 Secondary Emphysema

(Duration) yrs. mos. ds.

(Signed) W. E. Tull, M. D.

Sept 16, 1915 (Address) Salisbury, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and, (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 21 ds. In the State Delaware yrs. mos. ds.

Where was disease contracted, Worcester Co., Md.

If not at place of death? Worcester Co., Md.
 Former or usual residence Worcester Co., Md.

19 PLACE OF BURIAL OR REMOVAL To Hensley Worcester Co. Md. **DATE OF BURIAL** Sept 16, 1915

20 UNDERTAKER The Hill & Johnson Co. **ADDRESS** Salisbury

Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonæum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

County WicomicoVillage or City Hebron (No. _____, _____ St.; _____ Ward)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 338

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Baby Watson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Sept 13, 1915
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. 2 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Wicomico Co

10 NAME OF FATHER Hiram Watson

11 BIRTHPLACE OF FATHER (State or country) Wicomico

12 MAIDEN NAME OF MOTHER Emma Smith

13 BIRTHPLACE OF MOTHER (State or country) Pitts ville Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Hiram Watson(Address) Hebron Md

15 Filed Sept. 16, 1915 H. S. Phillips

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 15, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 13, 1915 to Sept 15, 1915, that I last saw him alive on 15, 1915

and that death occurred on the date stated above, at 11 P m.
The CAUSE OF DEATH* was as follows:

Pneumonia - Broncho
700

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. C. Connors, M. D.
Sept 16, 1915 (Address) Hebron Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. in the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, if not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Mardella Springs Md. DATE OF BURIAL Sept. 16, 1915

20 UNDERTAKER Buried by Father and ADDRESS Hebron Md

Wm Watson

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

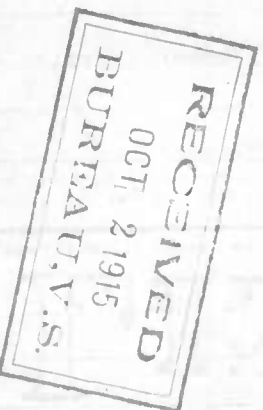
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles, Whooping cough, Chronic valvular heart disease, Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



MARGIN RESERVED FOR BINDING

V. S. No. 1.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH
County Wicomico 16045 (98)
Village or City Salisbury (No. Camden Dist. St.; 13 Ward)
2 FULL NAME Mary West Registration Dist. No. 333
[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>married</u> (Write the word)		
6 DATE OF BIRTH <u>Aug 18 1888</u> (Month) (Day) (Year)				
7 AGE <u>36</u> yrs. <u>1</u> mos. <u>7</u> ds.		If LESS than 1 day, hrs. OR min.?		
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <u>Md</u>				
PARENTS	10 NAME OF FATHER <u>Unknown</u>			
	11 BIRTHPLACE OF FATHER (State or country)			
	12 M maiden NAME OF MOTHER <u>Leah E Gray</u>			
13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>				

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John B West
(Address) Salisbury Md

15 Filed Sept. 27, 1915 May Turner
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH	
16 DATE OF DEATH <u>Sept. 25</u> , 191 <u>5</u> (Month) (Day) (Year)	
17 I HEREBY CERTIFY, That I attended deceased from <u>Sept. 23</u> , 191 <u>5</u> , to <u>Sept 25</u> , 191 <u>5</u> , that I last saw him alive on <u>Sept. 25</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>5 P.</u> m. The CAUSE OF DEATH * was as follows: <u>Robert</u> <u>Tubercular Pneumonia</u> (Duration) yrs. mos. <u>5</u> ds. Contributory <u>Heart Failure</u> Secondary (Duration) yrs. mos. ds. (Signed) <u>W B Pitts</u> , M. D. <u>Sept. 26 1915</u> (Address) <u>Salisbury Md</u> State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.	
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State, yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence	
19 PLACE OF BURIAL OR REMOVAL <u>Brown's Cemetery</u>	DATE OF BURIAL <u>Sept 27</u> , 191 <u>5</u>
20 UNDERTAKER <u>McClowry & Co</u>	ADDRESS <u>Salisbury Md</u>

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

gus, peritoneum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *telæmus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Wicomico</u> 16046 53		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Salisbury</u> (No. <u>Salisbury</u> Dist. <u>9th</u> St.; <u>9th</u> Ward)		Registration Dist. No. <u>333</u>	
2 FULL NAME <u>Elizabeth Whitney</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Widow</u>	
6 DATE OF BIRTH <u>May 18</u> , 18 <u>85</u> (Month) (Day) (Year)			
7 AGE <u>80</u> yrs. <u>4</u> mos. <u>9</u> ds.		It LESS than 1 day.....hrs. OR.....min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Virginia</u>			
PARENTS	10 NAME OF FATHER <u>John W. Williams</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>		
	12 MAIDEN NAME OF MOTHER <u>Nancy Danson</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Virginia</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>A. E. Booth</u> (Address) <u>Salisbury, Md.</u>			
15 Filed <u>Sept. 28, 1915</u> <u>May Turner</u> Deputy REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Sept. 27</u> , 191 <u>5</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Aug 1</u> , 191 <u>5</u> , to <u>Sept. 27</u> , 191 <u>5</u> , that I last saw her alive on <u>Sept. 27</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>6 A.</u> m.			
The CAUSE OF DEATH was as follows: <u>Suffocation from pressure</u> <u>Tracheal disease</u> <u>Hodgskin Disease</u> (Duration) <u>1</u> yrs. <u>0</u> mos. <u>0</u> ds. (Duration) <u>1</u> yrs. <u>0</u> mos. <u>0</u> ds.			
Contributory Secondary <u>Tracheal disease</u> (Signed) <u>W. H. H. H.</u> , M. D. <u>Sept. 28</u> , 191 <u>5</u> (Address) <u>Salisbury, Md.</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. In the State <u>0</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, If not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL <u>Mt. Vernon Somerset Co. Md.</u>		DATE OF BURIAL <u>Sept. 29th</u> , 191 <u>5</u>	
20 UNDERTAKER <u>The Hill & Johnson Co.</u>		ADDRESS <u>Salisbury Md.</u>	
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.			

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not painfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicemia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH			STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Anne Arundel</u>			Registration Dist. No. <u>336</u>	
Village or City <u>New Orleans</u> (No. <u>16047</u>)			St.; Ward	
[If death occurred in a hospital or institution, give its NAME instead of street and number.]				
2 FULL NAME <u>Francis Williams</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>A. A.</u>	5 SINGLE, MARRIED, WIDOWED, <u>yes</u> OR DIVORCED (Write the word)		
6 DATE OF BIRTH <u>1873</u> (Month) (Day) (Year)				
7 AGE <u>about 42</u> yrs. — mos. — ds. If LESS than 1 day, — hrs. OR — min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>sewn Housework</u> (b) General nature of industry, business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <u>North Carolina</u>				
PARENTS	10 NAME OF FATHER <u>John Savage</u>			
	11 BIRTHPLACE OF FATHER (State or country) <u>North Carolina</u>			
	12 MAIDEN NAME OF MOTHER <u>unknown</u>			
	13 BIRTHPLACE OF MOTHER (State or country) <u>unknown</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Annie Jones</u> (Address) <u>Belmar Md.</u>				
15 Filed <u>Sept 8</u> , 191 <u>5</u> <u>W. Y. Dunn</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Sept 4</u> , 191 <u>5</u> (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>Sept 4</u> , 191 <u>5</u> , to <u>Sept 4</u> , 191 <u>5</u> , that I last saw h <u>e</u> alive on <u>July 1st</u> , 191 <u>5</u> , and that death occurred on the date stated above, at <u>7 P</u> m.				
The CAUSE OF DEATH* was as follows: <u>Albuminuria</u> <u>Chronic nephritis</u> <u>OSJB</u>				
Contributory <u>Don't know</u> (Duration) — yrs. — mos. — ds.				
Secondary <u>Don't know</u> (Duration) — yrs. — mos. — ds.				
(Signed) <u>Robert Allegood</u> , M. D. <u>Sept 10</u> , 191 <u>5</u> (Address) <u>Belmar Del</u>				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds. Where was disease contracted, If not at place of death? — Former or usual residence —				
19 PLACE OF BURIAL OR REMOVAL <u>Union Cemetery</u> DATE OF BURIAL <u>Sept 18</u> , 191 <u>5</u>				
20 UNDERTAKER <u>J. Stewart</u> ADDRESS <u>Salisbury Md</u>				

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

OCT 2 1915

BUREAU, U.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Neomiss

16048

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 330Village or City Mardela Spgs.

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Nancy M. Wilson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH

Nov 18, 1856
(Month) (Day) (Year)

7 AGE

58 yrs. 10 mos. 13 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work House Wife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country) Neomiss Co.

PARENTS

10 NAME OF FATHER

Benjamin P. Gravenor11 BIRTHPLACE OF FATHER
(State or country)Neomiss Co.

12 MAIDEN NAME OF MOTHER

Elmer Bennett.13 BIRTHPLACE OF MOTHER
(State or country)Neomiss Co.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William P. Wilson

(Address)

Edgewater, Md.

15

Filed 9, 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 5, 1915
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Sept 3, 1915 to Sept 5, 1915.that I last saw her alive on Sept 5, 1915.and that death occurred on the date stated above, at 11 P. m.

The CAUSE OF DEATH* was as follows:

Chronic Parenchymatous Nephritis

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

H. C. Cornaway, M. D.Sept 6, 1915 (Address) Hebron, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Mardela Spgs.

DATE OF BURIAL

Sept 8, 1915

20 UNDERTAKER

H. D. Gravenor & Co.

ADDRESS

Sharpton.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faintly employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-sen-tial"), "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puer-peral septicæ-mia," "Puer-peral peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—ac-cident*; *Revol-ver wound of head—homicide*; *Poisoned by car-bolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
OCT. 6 1915
BUREAU, V.S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Wicomico</u> 16049 (66)			STATE OF MARYLAND CERTIFICATE OF DEATH		
Village or City <u>near Salisbury</u> (No. <u>Salisbury Dist.</u> St.; <u>P</u> Ward)			Registration Dist. No. <u>333</u>		
2 FULL NAME <u>Monimia Wright</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Sp. American</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)			
6 DATE OF BIRTH <u>July 28, 1866</u> (Month) (Day) (Year)					
7 AGE <u>49</u> yrs. <u>1</u> mos. <u>12</u> ds. If LESS than 1 day, ____ hrs. OR ____ min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Md.</u>					
PARENTS	10 NAME OF FATHER <u>Nathan Ring</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>				
	12 MAIDEN NAME OF MOTHER <u>Monimia Colman</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wilmer Wright</u> (Address) <u>Salisbury Md.</u>					
15 Filed <u>Sept. 11, 1915</u> <u>Gray Turner</u> Deputy REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Sept. 10, 1915</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Sept. 28</u> , 1915, to <u>Sept. 28</u> , 1915, that I last saw her alive on <u>Aug. 28</u> , 1915, and that death occurred on the date stated above, at <u>10 am.</u>					
The CAUSE OF DEATH * was as follows: <u>Paralysis</u> <u>from personal knowledge Aug. 28</u> (Duration) ____ yrs. ____ mos. ____ ds.					
Contributory Secondary (Duration) ____ yrs. ____ mos. ____ ds. (Signed) <u>N. P. Wark</u> , M. D. <u>Sept. 11, 1915</u> (Address) <u>Salisbury Md.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State, ____ yrs. ____ mos. ____ ds. Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Salisbury Md.</u>				DATE OF BURIAL <u>Sept. 12, 1915</u>	
20 UNDERTAKER <u>Holloway & Co.</u>				ADDRESS <u>Salisbury Md.</u>	

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of Occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Plowman*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*, (a) *Salesman*, (b) *Grocery*, (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of Cause of Death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*, *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Aschemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

County Wicomico

16050

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 233

Village or City Salisbury (No. Salisbury Dist. St. 9 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Nellie V. Wright

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Nov 26, 1914
(Month) (Day) (Year)

7 AGE 9 yrs. 23 mos. 23 ds. If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) MD

PARENTS 10 NAME OF FATHER Daniel Gale 11 BIRTHPLACE OF FATHER (State or country) MD 12 MOTHER NAME OF MOTHER Nellie Wright 13 BIRTHPLACE OF MOTHER (State or country) MD

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Nellie Wright
708 Lakewood
(Address) Salisbury, MD

15 Filed Sept. 20, 1915 May Tinner
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Sept 20, 1915
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw him alive on _____, 191____,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH * was as follows:

Had no doctor
Nothing + Diarrhea
(Duration) yrs. mos. ds.

Contributory Improper feeding
Secondary (Duration) yrs. mos. ds.

(Signed) CR Tinner M. O.
Sept 20, 1915 (Address) Salisbury, MD

*State the DISEASE CAUSING DEATH; or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State, yrs. mos. ds.
Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Pattons field DATE OF BURIAL Sept 20, 1915

20 UNDERTAKER Holloway & Co ADDRESS Salisbury, MD

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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